



# Antioch Brentwood Pediatric Dentistry

THE INFORMATION YOU INCLUDE ENABLES US TO PROVIDE BETTER CARE FOR YOUR CHILD

Child's name \_\_\_\_\_ Nickname \_\_\_\_\_  
 \_\_\_\_\_  
 First Middle Last  
 Sex: M \_\_\_ F \_\_\_ Birthdate \_\_\_\_\_ Adoption or guardianship \_\_\_\_\_  
 What is the reason for this visit? \_\_\_\_\_  
 Is this your child's first dental visit? \_\_\_\_\_ Date of last visit? \_\_\_\_\_ Purpose \_\_\_\_\_  
 What was your child's attitude towards previous dental care? \_\_\_\_\_  
 Have we seen other children in your family? \_\_\_\_\_  
 Name and age of brothers and sisters \_\_\_\_\_  
 Name of child's pet \_\_\_\_\_ Child's interests \_\_\_\_\_  
 Name of family dentist \_\_\_\_\_ Child's previous dentist \_\_\_\_\_  
 Who may we thank for referring you to our office? \_\_\_\_\_

## MEDICAL INFORMATION

Child's pediatrician \_\_\_\_\_ Phone number \_\_\_\_\_  
 Date of last physical exam \_\_\_\_\_ Is your child under a doctor's care now? \_\_\_\_\_  
 For what reason? \_\_\_\_\_  
 Is your child taking any medication or drugs? \_\_\_\_\_ Please list: \_\_\_\_\_  
 For what reason? \_\_\_\_\_  
 Has your child ever been hospitalized? \_\_\_\_\_ When? \_\_\_\_\_  
 For what reason? \_\_\_\_\_  
 Is your child allergic to any medications? \_\_\_\_\_ Please list: \_\_\_\_\_  
 Describe the reaction \_\_\_\_\_  
 Does your child have an allergic reaction to food? \_\_\_\_\_ animals? \_\_\_\_\_ pollen? \_\_\_\_\_ dust? \_\_\_\_\_ latex? \_\_\_\_\_  
 Does your child have good physical co-ordination? \_\_\_\_\_  
 Are your child's immunizations up-to-date? \_\_\_\_\_

Has your child had a history or difficulty with any of the following:

				YES	NO		
YES	NO	YES	NO	___	___	Hearing Difficulties	
___	___	___	___	___	___	Earaches	
___	___	___	___	___	___	Gag Reflex	
___	___	___	___	___	___	Motion Sickness	
___	___	___	___	___	___	Cancer or Malignancies	
___	___	___	___	___	___	Kidney Problems	
___	___	___	___	___	___	Fainting or Dizziness	
___	___	___	___	___	___	Speech Disorder	
___	___	___	___	___	___	Reflux or Regurgitation	
___	___	___	___	___	___	Eczema	

Comments/Details \_\_\_\_\_

Reviewed History:

Does your child have any phobias? \_\_\_\_\_ Any emotional or school problems? \_\_\_\_\_  
 How would you describe your child's learning: Slow \_\_\_\_\_ Average \_\_\_\_\_ Accelerated \_\_\_\_\_

To the best of my knowledge the above information is true. **Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

## DENTAL INFORMATION

Was your child bottle fed? \_\_\_\_\_ Until what age? \_\_\_\_\_ Breast fed? \_\_\_\_\_ Until what age? \_\_\_\_\_

Does your child have any mouth habits such as: finger/thumb sucking \_\_\_\_\_ tooth grinding \_\_\_\_\_  
lip sucking \_\_\_\_\_ mouth breathing \_\_\_\_\_ pacifier \_\_\_\_\_ nail biting \_\_\_\_\_ other \_\_\_\_\_

Has your child ever had any injuries to his/her teeth, mouth or head? \_\_\_\_\_  
If yes, please describe \_\_\_\_\_

Has your child taken fluoride? \_\_\_\_\_ In what form and when? \_\_\_\_\_

Does your child brush regularly? \_\_\_\_\_ Does an adult assist with brushing? \_\_\_\_\_

Does your child use dental floss? \_\_\_\_\_ Does an adult assist with flossing? \_\_\_\_\_

Has either parent or child been treated orthodontically? \_\_\_\_\_

How do you expect your child to behave in our office? \_\_\_\_\_

Describe your child: Outgoing \_\_\_\_\_ Shy \_\_\_\_\_ Stubborn \_\_\_\_\_ Anxious \_\_\_\_\_ Frightened \_\_\_\_\_ Regular kid \_\_\_\_\_

How may we make this visit a positive experience for your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## GENERAL INFORMATION

**This information is requested for financial and credit purposes.**

Name of person who is financially responsible for this child \_\_\_\_\_

**FATHER** (full name) \_\_\_\_\_ Date of birth \_\_\_\_\_ Marital status \_\_\_\_\_

Home address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Home phone \_\_\_\_\_

Employer: \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Work phone \_\_\_\_\_

Social security number \_\_\_\_\_ Driver's license number \_\_\_\_\_

Email: \_\_\_\_\_

**MOTHER** (full name) \_\_\_\_\_ Date of birth \_\_\_\_\_ Marital status \_\_\_\_\_

Home address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_ Home phone \_\_\_\_\_

Employer: \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_ Work phone \_\_\_\_\_

Social security number \_\_\_\_\_ Driver's license number \_\_\_\_\_

Email: \_\_\_\_\_

Child resides with: Both parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_

Name of nearest relative not living with you \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City/Zip \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

## INSURANCE INFORMATION AND CONSENT

**FATHER:** Name of Insurance Company \_\_\_\_\_ Group/Policy No. \_\_\_\_\_

Address \_\_\_\_\_ Union Local \_\_\_\_\_

**MOTHER:** Name of Insurance Company \_\_\_\_\_ Group/Policy No. \_\_\_\_\_

Address \_\_\_\_\_ Union Local \_\_\_\_\_

**Assignment of Benefits:** I hereby authorize payment of the group dental benefits otherwise payable to me but not to exceed the charges shown on the claim. I understand that I am financially responsible for any charges not covered by this authorization.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Consent:** I give the dentist permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand, that when appropriate, credit bureau reports may be obtained.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**RELATIONSHIP TO PATIENT** \_\_\_\_\_